FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034256

Facility Name: MASON CITY AREA NURSING HOME

Address: 520 N. PRICE AVENUE (Number) Mason City (City) 61701 (Zip Code)

County: Mason

Telephone Number: (217) 482-5022 **Fax #** ( )

IDPA ID Number: 371168043001

Date of Initial License for Current Owners: 02/16/89

Type of Ownership:

xx	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
xx	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: CRAIG L. ATER **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Joyce Conrady
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) CRAIG L. ATER, Senior Vice President -- Finance
(Firm Name & Address) Heritge Enterprises
(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	33	Skilled (SNF)	33	12,045	1
2		Skilled Pediatric (SNF/PED)			2
3	33	Intermediate (ICF)	33	12,045	3
4		Intermediate/DD			4
5	31	Sheltered Care (SC)	31	11,315	5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,405	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,245	7,361	1,407	19,013	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	4,140	0	4,140	12
13	DD 16 OR LESS					13
14	TOTALS	10,245	11,501	1,407	23,153	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.39%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [XX]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [XX]

I. On what date did you start providing long term care at this location?
Date started 02/16/89

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 02/16/89 NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 1,407

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [XX] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [XX] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	184,900	10,600		195,500		195,500		195,500			1
2	Food Purchase		111,557		111,557		111,557		111,557			2
3	Housekeeping	57,994	14,510		72,504		72,504		72,504			3
4	Laundry	38,635	5,195		43,830		43,830		43,830			4
5	Heat and Other Utilities			49,456	49,456		49,456		49,456			5
6	Maintenance	52,320	18,313	24,755	95,388		95,388		95,388			6
7	Other (specify):*											7
8	**TOTAL General Services**	333,849	160,175	74,212	568,235		568,235		568,235			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,040,900	67,378	4,192	1,112,470		1,112,470		1,112,470			10
10a	Therapy		39,369	111,273	150,641	(44,213)	106,428		106,428			10a
11	Activities	46,648	2,975		49,623		49,623		49,623			11
12	Social Services	20,296	434	1,428	22,159		22,159		22,159			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,107,844	110,156	125,893	1,343,893	(44,213)	1,299,680		1,299,680			16
	C. General Administration											
17	Administrative	58,803			58,803		58,803		58,803			17
18	Directors Fees											18
19	Professional Services			109,817	109,817		109,817	(2,157)	107,660			19
20	Dues, Fees, Subscriptions & Promotions			52,220	52,220	(36,135)	16,085	(6,043)	10,042			20
21	Clerical & General Office Expenses	124,315	11,926	16,272	152,513		152,513		152,513			21
22	Employee Benefits & Payroll Taxes			278,018	278,018		278,018		278,018			22
23	Inservice Training & Education			1,999	1,999		1,999		1,999			23
24	Travel and Seminar			4,342	4,342		4,342	(2,343)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			65,909	65,909		65,909		65,909			26
27	Other (specify):*			1,155	1,155		1,155	(700)	455			27
28	**TOTAL General Administration**	183,118	11,926	529,732	724,776	(36,135)	688,641	(11,243)	677,399			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,624,811	282,257	729,837	2,636,904	(80,348)	2,556,556	(11,243)	2,545,314			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MASON CITY AREA NURSING HOME #0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			118,129	118,129		118,129	(6,360)	111,769			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,252	7,252		7,252	(7,252)	(0)			32
33	Real Estate Taxes			2,353	2,353		2,353	(2,353)	(0)			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,054	3,054		3,054	(952)	2,102			35
36	Other (specify):*											36
37	TOTAL Ownership			130,788	130,788		130,788	(16,917)	113,871			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					44,213	44,213		44,213			39
40	Barber and Beauty Shops		447	11,514	11,960		11,960		11,960			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					36,135	36,135		36,135			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		447	11,514	11,960	80,348	92,308		92,308			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,624,811	282,703	872,139	2,779,653		2,779,653	(28,160)	2,751,493			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(952)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,360)	30		9
10	Interest and Other Investment Income	(7,252)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		27		18
19	Entertainment	(2,343)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,157)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(700)	27		24
25	Fund Raising, Advertising and Promotional	(6,043)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real estate taxes	(2,353)	33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (28,160)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (28,160)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MASON CITY AREA NURSING HOME

ID# 0034256

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$ 0	0	1
2		0	0	2
3		0	0	3
4		0	0	4
5		(952)	35	5
6		0	34	6
7		0		7
8		0		8
9		(6,360)	30	9
10			32	10
11		0		11
12		0		12
13		0	2	13
14		0	32	14
15		0	33	15
16		0	24	16
17		0	20	17
18		0	27	18
19			24	19
20		0	27	20
21		0		21
22		(2,157)	19	22
23		0		23
24		(700)	27	24
25		(6,043)	20	25
26		0	0	26
27		0	0	27
28		0	0	28
29		0	0	29
30		0	0	30
31		0	0	31
32				32
33		(2,353)	33	33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(18,565)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,157)	0	0	0	0	0	0	0	0	0	0	(2,157)	19
20	Fees, Subscriptions & Promotions	(6,043)	0	0	0	0	0	0	0	0	0	0	(6,043)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,343)	0	0	0	0	0	0	0	0	0	0	(2,343)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(700)	0	0	0	0	0	0	0	0	0	0	(700)	27
28	**TOTAL General Administration**	(11,243)	0	0	0	0	0	0	0	0	0	0	(11,243)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,243)	0	0	0	0	0	0	0	0	0	0	(11,243)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,360)	0	0	0	0	0	0	0	0	0	0	(6,360)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,252)	0	0	0	0	0	0	0	0	0	0	(7,252)	32
33	Real Estate Taxes	(2,353)	0	0	0	0	0	0	0	0	0	0	(2,353)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(952)	0	0	0	0	0	0	0	0	0	0	(952)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(16,917)	0	0	0	0	0	0	0	0	0	0	(16,917)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(28,160)	0	0	0	0	0	0	0	0	0	0	(28,160)	45

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$	Heritage Enterprises, Inc.	100.00%	$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$	Heritage Enterprises, Inc.	100.00%	$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [xx]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MASON CITY AREA NURSING HOME COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0034256

CONTACT PERSON REGARDING THIS REPORT Craig Ater

TELEPHONE (309)823-7135 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land			$ 36,000	1
2					2
3	TOTALS			$ 36,000	3

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	97		1989		$ 2,605,181	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1990 Improvements			1990	7,990						9
10	1991 Improvements			1991	16,512						10
11	1992 Improvements			1992	22,678						11
12	1993 Improvements			1993							12
13	1994 Improvements			1994	24,788						13
14	1995 Improvements			1995	17,777						14
15											15
16	Water Heater			1997	4,800						16
17	Asphalt Sealer			1997	5,395						17
18	Entrance & Walkway			1997	1,700						18
19	Landscaping			1997	6,770						19
20											20
21	Kitch Central A/C			1996	15,800						21
22	Central A/C Administrative Offices			1996	2,500						22
23	Landscapping			1996	2,710						23
24	Automatic Door Closers			1996	3,732						24
25											25
26	Life Safety Alarm			1998	992						26
27	Sound System Cafeteria			1998	1,442						27
28	Security System			1998	10,742						28
29											29
30	Parking Lot Paving			1999	4,190						30
31	Petroleum tank			1999	12,500						31
32											32
33											33
34	C/O Allocation										34
35	Book Depreciation					78,746		78,746		987,288	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Firewalls---ceilling	2000	$ 10,800	$		$	$	$	37
38	Facility Remodel--Materials (Carpeting)	2000	22,660						38
39									39
40	Wallpaper	2001	5,552						40
41	Carpet Installation	2001	4,141						41
42	Woodwork Refinishing	2001	418						42
43	Water Heater	2001	6,125						43
44	Facility Remodel--Labor	2001	1,520						44
45	Parking Lot	2001	9,375						45
46	Living room Remodel	2001	415						46
47	Facility Remodel--Materials	2001	23,795						47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62	Ceramic Tile Shower	2001	698						62
63	Hot Water Pump	2001	2,586						63
64	Carpeting and Installation	2001	2,208						64
65	Wander Guard	2001	1,270						65
66	Light Fixtures and Door	2001	2,777						66
67	Flooring	2001	1,311						67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,863,850	$ 78,746		$ 78,746	$	$ 987,288	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,863,850	$ 78,746		$ 78,746	$	$ 987,288	1
2									2
3	Painting	2002	1,500						3
4	Remodel & Update Nurses Station	2002	13,224						4
5	Decorative consulting	2002	3,982						5
6	Living room Remodel	2002	493						6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,883,049	$ 78,746		$ 78,746	$	$ 987,288	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 443,448	$ 33,023	$ 33,023	$		$ 375,192	71
72	Current Year Purchases	34,130						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 477,578	$ 33,023	$ 33,023	$		$ 375,192	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,396,627	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 111,769	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 111,769	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,362,480	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,102 Description: pager, computer equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$		$ 30,490	$		$ 30,490	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			12,279			12,279	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			62,648	1,011		63,659	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				38,358		38,358	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): x-ray	39/3				5,855			5,855	13
14	TOTAL			$		$ 111,273	$ 39,369		$ 150,641	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 387,267	$	1
2	Cash-Patient Deposits	4,282		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	303,952		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	46,907		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 742,408	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	83,500		13
14	Buildings, at Historical Cost	2,965,940		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	477,578		16
17	Accumulated Depreciation (book methods)	(1,369,899)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Tax Asset			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,157,119	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,899,527	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 76,139	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,282		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	170,535		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,205		32
33	Accrued Interest Payable	176		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits	9,108		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 261,445	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	107,050		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 107,050	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 368,495	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,531,032	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,899,527	$	48

***(See instructions.)**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,584,951	1
2	Restatements (describe):		2
3	Audit Adjustment		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,584,951	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(53,919)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (53,919)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,531,032	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,741,461	1
2	Discounts and Allowances for all Levels	(321,603)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,419,858	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	179,043	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 179,043	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	510	12
13	Barber and Beauty Care	14,343	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,282	16
17	Sale of Drugs	75,689	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	448	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 95,272	23
	D. Non-Operating Revenue		
24	Contributions	19,634	24
25	Interest and Other Investment Income***	7,067	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,701	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,720,874	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	568,235	31
32	Health Care	1,343,893	32
33	General Administration	724,776	33
	B. Capital Expense		
34	Ownership	130,788	34
	C. Ancillary Expense		
35	Special Cost Centers	11,960	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Loss from Non-Nursing property		37
38	Gain on Disposal	(4,861)	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,774,792	40
41	**Income before Income Taxes (line 30 minus line 40)****	(53,919)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (53,919)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,849	2,080	$ 51,454	$ 24.74	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	11,834	12,755	236,889	18.57	3
4	Licensed Practical Nurses	13,571	14,683	227,622	15.50	4
5	Nurse Aides & Orderlies	47,320	50,929	460,155	9.04	5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,437	5,974	64,779	10.84	8
9	Activity Director					9
10	Activity Assistants	5,353	5,471	46,648	8.53	10
11	Social Service Workers	1,883	2,083	20,296	9.74	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,770	23,158	184,900	7.98	15
16	Dishwashers					16
17	Maintenance Workers	5,322	5,708	52,320	9.17	17
18	Housekeepers	8,700	9,295	57,994	6.24	18
19	Laundry	3,853	4,292	38,635	9.00	19
20	Administrator	2,080	2,080	58,803	28.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,317	9,168	124,315	13.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,289	147,676	$ 1,624,811 *	$ 11.00	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		9,000		36
37	Medical Records Consultant		3,330		37
38	Nurse Consultant				38
39	Pharmacist Consultant		0		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		0		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 12,330		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joyce Conrady	Administrator	0	$ 58,803
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,803

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 96,000
Abbott & Co	Accounting	4,850
CNA Trust	401K	1,273
Carmin Little	Nurse Consulting	5,287
Illinois State	Employee Survey	250
Various	Legal	2,157
Legal Fees (Adjusted to zero)		0
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 109,817

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,310
Unemployment Compensation Insurance	1,756
FICA Taxes	124,298
Employee Health Insurance	88,288
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	31,367
Employee Benefits - central office	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 278,018

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	3,228
Health Care Worker Background Check	
(Indicate # of checks performed 20)	196
Central Office Allocation	0
Promotional Advertising	1,568
Public Relations	4,476
Dues and Subscriptions	5,723
License and Fees	495
Less: Public Relations Expense	(4,476)
Non-allowable advertising	(0)
Yellow page advertising	(1,568)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,042

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,993
	154
Seminar Expense	2,195
Non Allowable	(2,343)
Central Office Allocation	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **no** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **36,135**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **6,575**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Abbott & Co** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not complete as of this date**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount								
1009			PETTY CASH	387,267							1,009	387,267					
1010			CASH IN BANK								1,100	303,952					
1040			CASH IN BANK-PAYROLL								1,101						
1100			ACCOUNTS RECEIVABLE	303,952							1,110						
1110			MEDICARE RECEIVABLES								1,125						
1125			IPA INCOME RECEIVABLE								1,135						
1130			MEDICARE COST REPORT								1,140						
1135			ACCOUNTS RECEIVABLE-IC								1,145						
1140			UNAPPLIED CASH RECEIPTS								1,200	46,907					
1145			A/R SUSPENSE-REFUNDS								1,220						
1190			ACCRUED INTEREST REC								1,300						
1200			PREPAID INSURANCE	46,907							1,310						
1220			OTHER PREPAID EXPENSES								1,320						
1300			FOOD INVENTORY								1,409	83,500					
1310			SUPPLIES INVENTORY								1,450	477,578					
1409			LAND	83,500							1,460	-375,192					
1450			FURNITURE & EQUIPMENT	477,578							1,475	2,965,940					
1460			ACCUM DEPR-FURN & EQUIP	-375,192							1,490	-994,707					
1475			BUILDING & IMPROVEMENTS	2,965,940							1,530	4,282					
1490			ACCUM DEPR-BUILDING	-994,707							1,550						
1530			RESIDENT FUNDS	4,282							1,551						
1550			LOAN FEES	0							1,850	0					
1560			REAL ESTATE TAX ESCROW								2,010	-76,139					
1575			REIMBURSABLE PURCHASES								2,100	-82,516					
1850			INTRACOMPANY	0							2,100						
2010			ACCOUNTS PAYABLE	-76,139							2,100						
2095			BONUSES PAYABLE								2,100						
2100			ACCRUED PAYROLL	-82,516							2,110	-88,019					
2110			ACCRUED VACATION PAY	-88,019							2,120						
2120			UC TAXES PAYABLE								2,125						
2125			FICA TAX PAYABLE	0	0						2,130	0					
2130			FIT PAYABLE								2,140						
2140			STATE W/H PAYABLE		0						2,152						
2145			EARNED INCOME CREDIT								2,225						
2150			UC FED CREDIT REDUCTION								2,230						
2230			PAYROLL SAVINGS								2,235						
2235			IRA W/HOLDINGS								2,240						
2240			UNITED WAY								2,246						
2245			GROUP INSURANCE PAYABLE								2,250						
2246			GROUP INSURANCE PAYABLE-CAFETERIA								2,260						
2260			WAGE GARNISHMENTS								2,300	-176					
2280			MISC PAYROLL DEDUCTIONS								2,320	-9,108					
2300			ACCRUED INTEREST PAYABLE	-176							2,350	-1,205					
2310			SALES TAX PAYABLE								2,385						
2320			IPA PAYMENTS PAYABLE	-9,108							2,400						
2350			REAL ESTATE TAX PAYABLE	-1,205							2,512	-4,282					
2385			ACTIVITY FUND	0							2,600	-107,050					
2390			SECURITY DEPOSITS								2,600						
2391			VOLUNTEER FUND								2,625						
2393			HEART FUND/BAZAAR								2,625						
2395			DEFERRED INC EMP & MEM								2,695						
2400			CURRENT PORTION LT DEBT								2,720	-2,584,951					
2460			INCOME TAXES PAYABLE									53,919					
2512			DUE TO RESIDENTS	-4,282													
2600			MORTGAGE PAYABLE	-107,050													
2650			EQUIPMENT LOAN PAYABLE								balance	0					
2695			CURRENT PORTION LT DEBT														
2696			DEFERRED INCOME TAXES														
2710			COMMON STOCK														
2720			RETAINED EARNINGS	-2,584,951													
2970			PROFIT/LOSS FOR PERIOD	53,919													
3007.1			PATIENT DAYS-PRIVATE	15,089									3,007	3,007	PATIENT I	15,089	
3007.2			PATIENT DAYS-IPA	10,255									3,007	3,007	PATIENT I	10,255	
3007.3			PATIENT DAYS-MEDICARE	1,407									3,007	3,007	PATIENT I	1,407	
3007.4			PATIENT DAYS-CONVERSION										3,007			3,367	
3007.5			PATIENT DAYS-LICENSED										3,007				
3007.6			PATIENT DAYS-TOTAL										3,007				
3010		1	BASIC CHARGE-PRIVATE & VA	-1,218,249		0	0	0	0				3,007				
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0				3,010	3010	BASIC CH.	-1,218,249	
3020		1	BASIC CHARGE-IPA	-861,677		0	0	0	0				3,020	3020	BASIC CH.	-861,677	
3030		1	BASIC CHARGE-MEDICARE	-388,457		0	0	0	0				3,030	3030	BASIC CH.	-388,457	
3035		4	DAY CARE/HOME CARE			0	0	0	0				3,040	3040	LIGHT NU	-12,813	
3040		1	LIGHT NURSING CARE	-103,627		0	0	0	0				3,050	3050	MEDIUM N	-54,661	
3050		1	MEDIUM NURSING CARE			0	0	0	0				3,060	3060	HEAVY NU	-31,308	
3060		1	HEAVY NURSING CARE			0	0	0	0				3,061	3061	SKILLED N	-4,845	
3061		1	SKILLED NURSING CARE										3,080	3080	NURSING	-48,869	
3080		1	NURSING SUPPLIES-PRIVATE	-166,959		0	0	0	0				3,081	3081	NURSING	-59,322	
3081		1	NURSING SUPPLIES-IPA			0	0	0	0				3,082	3082	NURSING	-14,855	
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0				3,083	3083	NURSING	-43,913	
3083		1	NURSING SUPPLIES MED PT B										3,100	3100	DRUGS-MI	-75,689	
3100		17	DRUGS	-75,689		0	0	0	0				3,101				
3101		17	DRUGS-OTHER										3,110	3110	PHYSICAL	-9,109	
3110		6	PT-PRIVATE	-179,043		0	0	0	0				3,111				
3111		6	PT-IPA			0	0	0	0				3,112	3112	PHYSICAL	-69,840	
3112		6	PT-MEDICARE PART A			0	0	0	0				3,113	3113	PHYSICAL	-35,200	
3113		6	PT-MEDICARE PART B			0	0	0	0				3,140	3140	LABORAT	-3,933	
3130		1	PUBLIC AID ASSESSMENT INC										3,150				
3140		19	LABORATORY INCOME			0	0	0	0				3,151				
3150		6	SPEECH/OT-PRIVATE			0	0	0	0				3,152	3152	ST/OT THE	-48,800	
3151		6	SPEECH/OT-IPA			0	0	0	0				3,153	3153	ST/OT THE	-10,840	
3152		6	SPEECH/OT-MED PART A			0	0	0	0				3,160	3160	X-RAY SEI	-1,322	
3153		6	SPEECH/OT MED PART B										3,410				
3410		2	IPA DISCOUNTS	321,603		0	0	0	0				3,411	3410	IPA DISCO	57,966	
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0				3,420	3411	MEDICARI	5,700	
3420		2	MEDICARE DISCOUNTS			0	0	0	0				3,500	3420	MEDICARI	257,937	
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0				3,520	3520	RENT INC(	-4,282	
3520		16	RENT INCOME	-4,282		6	0	6	0				3,530	3530	BEAUTY S	-14,343	
3530		13	BEAUTY SHOP	-14,343		0	0	0	0				3,560	3560	ACTIVITY	-200	
3560		12	ACTIVITY FUND INCOME	-200		0	0	0	0				3,570	3570	VENDING	-310	
3570		12	VENDING INCOME/EXPENSE	-310		0	0	0	0				3,590	3590	EQUIPMEN	-2,492	
3580		12	MANAGEMENT FEES			0	0	0	0				3,595				
3590		1	EQUIPMENT RENTAL	-2,492		0	0	0	0				3,600	3600	MISC INC(	-448	
3595		21	RESIDENT TRANSPORTATION	0		0	0	0	0				4,110	4110	G&A WAG	114,507	
3600		21	MISC INCOME	-448		0	0	0	0				4,111	4111	ADMINIST	58,803	
4110			GENERAL & ADMINIST WAGES	114,507	124,315	21	1	17	0				4,115	4115	G&A PTO &	9,808	
4111			ADMINISTRATOR WAGES	58,803	58,803	17	1	0	0				4,120	4120	EMPLOYE	29,729	
4115			VACATION & SICK - G&A	9,808		21	1	0	0				4,125				
4120	4475		EMPLOYEE BENEFITS	31,367	278,018	22	3	0	0				4,130				
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0				4,135				
4130			EMPLOYEE SCHOLORSHIP WA(	0		21	1	0	0				4,250	4250	OFFICE SU	7,378	
4135			EMPLOYEE SCHOLORSHIP COS	0		23	3	0	0				4,255	4255	POSTAGE	2,783	
4220			DIRECTORS FEES			18	3	0	0				4,260	4260	TELEPHON	16,272	
4250	4255		OFFICE SUPPLIES	11,926	11,926	21	2	0	0				4,275	4275	TRAINING	1,999	
4260			TELEPHONE	16,272	16,272	21	3	0	0				4,276				
4275			TRAINING & EMPLOYEE DEVL	1,999	1,999	23	3	16	0				4,280	4280	GENERAL	1,993	
4280			GENERAL TRAVEL	1,993	4,342	24	3	16	0				4,281	4281	MEAL EXF	154	
4281			MEAL EXPENSE FOR TRAVEL	154		24	3	19	0				4,285	4285	EDUCATIO	1,828	
4285			EDUCATION & SEMINAR	2,195		24	3	19	-2,343	***			4,289	4289	MEETINGS	367	
4290			HELP WANTED ADVERTISING	3,228	52,220	20	3	0	0		-36,135		4,290	4290	HELP WAN	3,228	
4291			PROMOTIONAL ADVERTISING	1,568		20	3	25	-1,568				4,291	4291	PROMOTIO	1,568	
4292			PUBLIC RELATIONS	4,476		20	3	25	-4,476				4,292	4292	PUBLIC RI	4,476	
4300			LICENSES & FEES	37,030		20	3	17	0				4,300	4300	LICENSE &	37,030	
4310			DUES & SUBSCRIPTIONS	5,723		20	3	17	0				4,310	4310	DUES & SU	5,723	
4320			CONTRIBUTIONS	0		27	3	20	0				4,320				
4350			PROFESSIONAL FEES	13,817	109,817	19	3	22	-2,157				4,350	4350	PROFESSI(	13,817	
4355			MEDICAL DIRECTOR	9,000	9,000	9	3	0	0				4,355	4355	MEDICAL	9,000	
4360			UTILIZATION REVIEW	0		10	3	0	0				4,362	4361	OTHER PH	3,330	
4361			OTHER PHYSICIAN FEES			39	3	0	0				4,363				
4362			MEDICAL RECORDS CONSULT	3,330		10	3	0	0				4,364				
4363			PHARMACIST FEES	0		10	3	0	0				4,370	4370	TV RENTA	2,164	
4364			SOC SERV/ACT CONSULT	0	0	12	3	0	0				4,383	4383	BACKGRO	196	
4370			TV RENTAL	2,164		35	3	5	-952				4,390				
4380			INCOME TAXES	0	1,155	27	3	26	0				4,400	4400	PAYROLL	119,950	
4383			BACKGROUND CHECKS	196		20	3	26	0				4,401	4401	PAYROLL	6,104	
4400			PAYROLL TAXES	119,950		22	3	0	0				4,410	4410	GROUP IN	88,288	
4401			PAYROLL TAXES ADMINIST	6,104		22	3	0	0				4,420	4420	LIABILITY	65,909	
4410			GROUP INSURANCE	88,288		22	3	0	0				4,430	4430	WORKMA	32,310	
4420			LIABILITY INSURANCE	65,909	65,909	26	3	0	0				4,435				
4425			INSURANCE-OWNERS			22	3	21	0				4,436				
4430			WORKMENS COMP INSURANCI	32,310		22	3	0	0				4,450	4450	MANAGEM	96,000	
4450			CENTRAL OFFICE FEES	96,000		19	3	34	0				4,460	4461	BAD DEBT	700	
4460			BAD DEBTS	700		27	3	24	-700				4,461				
4470			LOST ITEMS-RESIDENTS	0		27	3	0					4,470				
4490			MISCELLANEOUS	455		27	3	0	0				4,475	4475	UNIFORM	1,638	
4510			REAL ESTATE TAXES	2,353	2,353	33	3	0	-2,353				4,486	4486	SERVICE (	7,466	
4600			LEASED EQUIPMENT	890	3,054	35	3	16	0				4,490	4490	MISC EXPI	455	
5110			MAINTENANCE SALARIES	49,374	52,320	6	1	0	0				4,496	4496	MISC. M.I.	1,765	
5120			MAINTENANCE SICK & VAC	2,946		6	1	0	0				4,510	4510	REAL EST.	2,353	
5130			ELECTRIC	33,294	49,456	5	3	0	0				4,600	4600	LEASED E	890	
5131			NATURAL GAS	7,934		5	3	0	0				5,110	5110	MAINTEN.	49,374	
5132			HEATING & DEISEL OIL			5	3	0	0				5,120	5120	MAINTEN.	2,946	
5133			WATER & SEWER	8,228		5	3	0	0				5,130	5130	ELECTRIC	33,294	
5134			TRASH COLLECTION	2,583	24,755	6	3	0	0				5,131	5131	NATURAL	7,934	
5140			PROPERTY PLANT REPLACEMI	2,383	18,313	6	2	0	0				5,133	5133	WATER &	8,228	
5160			GENERAL REPAIR & MAINT	15,930		6	2	0	0				5,134	5134	TRASH CC	2,583	
5165			MAINTENANCE CONTRACTS	22,173		6	3	0	0				5,140	5140	PROP/PLA	2,383	
5210			DIETARY WAGES	171,021	184,900	1	1	0	0				5,160	5160	GENERAL	15,930	
5220			DIETARY SICK & VAC	13,878		1	1	0	0				5,165	5165	MAINTEN.	14,706	
5240			SALES TAX			2	3	13	0				5,210	5210	DIETARY '	171,021	
5248			FOOD PURCHASES	118,131	111,557	2	2	0	0				5,220	5220	DIETARY I	13,878	
5250			SUPPLIES-DISHWASHING	4,328	10,600	1	2	0	0				5,248	5248	FOOD PUR	118,131	
5260			DIETARY REPLACEMENT	1,231		1	2	0	0				5,250	5250	SUPPLIES	4,328	
5270			KITCHEN SUPPLIES-PAPER	5,041		1	2	0	0				5,260	5260	REPLACEI	1,231	
5295			MEAL CREDIT	-6,575		2	2	0	0				5,270	5270	KITCHEN	5,041	
5310			LAUNDRY WAGES	35,724	38,635	4	1	0	0				5,295	5295	MEAL INC	-6,575	
5340			LAUNDRY SICK & VAC	2,911		4	1	0	0				5,310	5310	LAUNDRY	35,724	
5370			LAUNDRY REPLACEMENT	1,926	5,195	4	2	0	0				5,340	5340	LAUNDRY	2,911	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0				5,370	5370	REPLACEI	1,926	
5390			LAUNDRY SUPPLIES	3,270		4	2	0	0				5,380	5380	OUTSIDE I	53	
5410			HOUSEKEEPING WAGES	53,845	57,994	3	1	0	0				5,390	5390	SUPPLIES	3,217	
5440			HOUSEKEEPING SICK & VAC	4,150		3	1	0	0				5,410	5410	HOUSEKE	53,845	
5480			HOUSEKEEPING SUPPLIES	4,994	14,510	3	2	0	0				5,440	5440	HOUSEKE	4,150	
5490			HOUSEKEEPING SUPPLIES-PPR	9,516		3	2	0	0				5,480	5480	SUPPLIES-	4,994	
6010			RN WAGES-MEDICARE		1,040,900	10	1	0	0				5,490	5490	SUPPLIES-	9,516	
6020			RN WAGES-NON MEDICARE	222,072		10	1	0	0				6,020	6020	RN WAGE	222,072	
6030			DON WAGES	51,454		10	1	0	0				6,030	6030	DON WAG	51,454	
6035			ADON	0		10	1	0	0				6,035				
6040			RN SICK & VACATION	14,817		10	1	0	0				6,040	6040	RN PTO &	14,817	
6110			LPN WAGES-MEDICARE	0		10	1	0	0				6,120	6120	LPN WAGI	217,010	
6120			LPN WAGES-NON MEDICARE	217,010		10	1	0	0				6,140	6140	LPN PTO &	10,613	
6130			LPN WAGES OTHER			10	1	0	0				6,220	6220	AIDES WA	432,915	
6140			LPN SICK & VACATION	10,613		10	1	0	0				6,240	6240	AIDES PT(	27,240	
6210			AIDE WAGES-MEDICARE			10	1	0	0				6,245				
6220			AIDE WAGES-NON MEDICARE	432,915		10	1	0	0				6,246				
6230			WARD CLERKS			10	1	0	0				6,247				
6240			AIDE VACATION & SICK	27,240		10	1	0	0				6,250				
6245			CONTRACT NURSES-RN	0		10	3	0	0				6,255				
6246			CONTRACT NURSES-LPN	0		10	3	0	0				6,260				
6247			CONTRACT NURSES-AIDES	0		10	3	0	0				6,270	6270	REHAB W.	59,732	
6250			NURSE AIDE TRAINING WAGES	0	0	13	1	0	0				6,275	6275	REHAB PT	5,047	
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0				6,290	6290	NURSING	54,263	
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0				6,295	6295	NURSING	13,115	
6270			REHAB WAGES	59,732		10	1	0	0				6,390				
6275			REHAB SICK & VAC	5,047		10	1	0	0				6,490	6490	OTHER	862	
6280			NURSING DEPT EDUCATION			23	3	0	0				7,280	7280	DRUG PUI	38,358	
6290			NURSING SUPPLIES	54,263	67,378	10	2	0	0				7,281				
6295			NURSING SUPPLIES	13,115		10	2	0	0				7,380	7380	LABORAT	5,307	
6390			REPLACEMENT-NURSING	0		10	2	0	0				7,391	7390	X-RAY SEI	422	
6490			NURSING OTHER	862	4,192	10	3	0	0				7,393	7393	OTHER A S	127	
7280			DRUG PURCHASES	38,358	39,369	39	2	0	0	***			7,510	7510	ACTIVITIE	44,767	
7281			DRUG PURCHASES-OTHER	0		39	2						7,540	7540	ACTIVITIE	1,882	
7380			LABORATORY SERVICES	5,855	111,273	39	3	0	0				7,590	7590	ACTIVITIE	2,975	
7410			HOME HEALTH SALARY			39	1	0	0				7,620	7620	PHYSICAL	62,648	
7440			HOME HEALTH SICK & VAC			39	1	0	0				7,660	7660	P.T. SUPPL	1,011	
7450			HOME HEALTH EXPENSES			39	3	0	0				7,710	7710	SOCIAL SE	20,296	
7510			ACTIVITES WAGES	44,767	46,648	11	1	0	0				7,720				
7540			ACTIVITIES SICK & VAC	1,882		11	1	0	0				7,730	7730	SOCIAL SE	434	
7590			ACTIVITIES SUPPLIES	2,975	2,975	11	2	0	0				7,740	7740	OCCUPAT	30,490	
7595			ACTIVITIES FEES	0	0	11	3	0	0				7,750	7750	SOCIAL C(	1,428	
7610			PT WAGES			39	1	0	0				7,770	7770	SPEECH TI	12,279	
7611			PT SICK & VACATION			39	1	0	0				7,820	7820	BEAUTICI	11,514	
7620			PT FEES	62,648		39	3	0	0	***			7,890	7890	BEAUTY S	447	
7660			PT SUPPLIES	1,011		39	2	0	0				7,960				
7710			SOCIAL SERVICE WAGES	20,296	20,296	12	1	0	0				8,120	8120	INTEREST	7,252	
7720			SOCIAL SERVICE SICK & VAC	0		12	1	0	0				8,125				
7730			SOCIAL SERVICE EXPENSES	434	434	12	2	0	0				8,130	8130	DEPRECIA	118,129	
7740			OT FEE	30,490		39	3	0	0	***			8,150				
7750			SOCIAL THERAPIST FEE	1,428	1,428	12	3	0	0				9,510	9510	INTEREST	-7,067	3,254
7770			SPEECH THERAPY FEE	12,279		39	3	0	0	***			9,520	9520	MISC NON	-19,634	
7800			BEAUTICIAN WAGES		0	40	1	0	0				9,530	9531	PROCEEDS	-4,861	36,057
7810			BEAUTICIAN SICK & VAC			40	1	0	0								
7820			BEAUTICIAN FEES	11,514	11,514	40	3	0	0							53,919	
7890			BEAUTY SHOP SUPPLIES	447	447	40	2	0	0								
7910			VOLUNTEER COORDINATOR			21	1	0	0								
7940			VOL COORD SICK & VAC			21	1	0	0								
7960			VOL COORD SUPPLIES	0		21	2	0	0								
8100			RENT		0	34	3	0	0								
8120			INTEREST EXPENSE	7,252	7,252	32	3	14	-7,252								
8130			DEPRECIATION	118,129	118,129	30	3	9	-6,360								
8150			LOAN FEE AMORTIZATION	0		32	3	0	0		36,135						
9510			INTEREST INCOME	-7,067		32	0	10	0								
9520			MISC NON-OPERATING INCOM	-19,634		0	0	0	0								
9700			INCOME TAXES	-4,861		0	0	0	0								
				2,748,092	2,779,653												
					31,561												
GRAND TOTALS				53,919					-28,160								
				(NET INCOME)													
				0													

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0
173,113

	G/L	RECAP CENSUS
PP	15,089	11,501
IPA	10,255	10,245
medicare	1,407	1,407
		23,153
IPA BEDHOLDS	10	
PP BEDHOLDS	221	
PP CONVERS	3,367	